New York State Department of Health
Bureau of Emergency Medical Services
EMS Memorial Nomination Form

NOMINEE INFORMATION

Please provide the following information about the person being considered for the EMS memorial:			
Name of Nominee:		EMT #	
Date of Birth:		Date of Death:	
Please provide the following information about the nominee's agency:			
Name:		Agency #	
Contact:			
Phone:		Fax:	
Pager/Cell Phone:		E-mail:	
Address:			
City, State, Zip:			
Please provide the following information about the nominee's Primary Survivor(s) (usually spouse or parents):			
Name:		Relationship:	
Phone:		Fax:	
Pager/Cell Phone:		E-mail:	
Address:			
City, State, Zip:			

NOMINATOR INFORMATION

Please provide the following information about the person submitting this nomination:			
Name:			
Phone:		Fax:	
Pager/Cell Phone:		E-mail:	
Address:			
City, State, Zip:			
Relationship:			
Signature:			

NARRATIVES

Please describe the circumstances of nominee's death, cause of death and how related to a medical call:

Please give a brief description of the nominee's activities in emergency medical services:

Please list any additional facts you think may be relevant:

MEDIA INFORMATION

Please provide informatiion on all media outlets that covered the nominee's death or the circumstances surrounding the death.

Outlet Type:			
Name/Call Letters:			
Address:			
City, State, Zip:			
Telephone:		E-mail:	